Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Disabilities (Adults)

Issued by the Chief Inspector

Name of designated centre:	Inbhear Na Mara
Name of provider:	Health Service Executive
Address of centre:	Donegal
Type of inspection:	Unannounced
Date of inspection:	03 December 2019
Centre ID:	OSV-0002496
Fieldwork ID:	MON-0024222

About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

Inbhear Na Mara provides accommodation for 10 adults over the age of 18 years with an Intellectual disability who have high support and complex needs in terms of their physical and medical needs. The unit was purpose built to accommodate persons with complex needs and all accommodation is at ground level and is suitable for wheelchair users or people with limited mobility. All bedrooms are single occupancy and some have direct access to the garden areas via double doors. Residents have access to a range of communal seating areas, a dining room and quiet room where residents can spend time alone if they wish. In addition to shared toilet and bathing facilities a number of residents have en suite shower and toilet facilities. The centre is located in a small town and is staffed 24 hours with nurses on duty at all times.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	9

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended. To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 3 December 2019	09:00hrs to 15:00hrs	Julie Pryce	Lead
Tuesday 3 December 2019	09:00hrs to 15:00hrs	Gary Kiernan	Support

What residents told us and what inspectors observed

There were seven residents on the day of the inspection, few of whom, due to their disability, were able to describe their daily life to the inspectors. Therefore inspectors engaged with them according to their choice, viewed their interactions with staff and observed their daily life on the day of the inspection.

Some residents went out for the day and activities within the centre were available to others. However, inspectors saw that several residents were unoccupied for significant parts of the day. There were lengthy periods of time where residents were unengaged and behaviours such as rocking and vocalising were observed.

Residents had no access to a kitchen or laundry facilities, meaning that they did not have full opportunity to engage in the normal activities of daily life.

The inspectors observed staff interacting with residents in a caring way and it was evident that staff and residents knew each other well and could communicate effectively and in an easy way. However there were institutional practices still in place, such as the wearing of plastic gloves when offering a hand massage. There were set times for meals and night time routines where it was not evident that these had been chosen by residents. Inspectors read entries in the personal plan for a resident which said 'I don't want to go to bed at 7.30 in the evening'. There was no rationale available to support this early bed time, and no evidence that this had been changed in response to the resident's wishes.

Overall this centre was observed to be an institutional type setting, and there was little indication that residents were supported in a homelike environment which was organised and managed in line with their preferences and wishes.

Capacity and capability

This designated centre was not effectively managed and monitored to ensure a service that was person centred and designed around the preferences of residents. The lines of responsibility and accountability in the centre were not sufficiently clear as a key management position in the centre was not filled. The identified person in charge was the area manager who was not based in the centre. It was not evident that this arrangement was effective as management functions had been devolved to personnel who lacked the authority to carry out these duties.

The provider had, however, recognised to some degree that improvements were required in the centre. In response the provider had carried out a quality review of the service on 20 November and was in the process of updating and implementing a

quality improvement plan to bring about a better service for residents. However, It was noted that some of the issues identified during this inspection such as general welfare of residents, institutional routines, staffing arrangements and residents' rights had not been identified during this most recent quality review. As a result the provider was not demonstrating the capacity to effectively identify and address areas of concern in the centre.

While there was an agreed audit schedule this had not been effective. In a number of cases audits which should have taken place had not been carried out. Where required actions were identified through audit many of these actions had not been implemented or monitored, including the identified requirement for a local manager.

Where audits took place, the required actions from these audits had not been included in the overall quality improvement plan. The responsibility for some of these actions, which are the responsibility of the person in charge, had in some cases been devolved to staff who did not have the authority or accountability to effect the required changes.

While six monthly unannounced visits on behalf of the provider had taken place as required, identified actions had not been progressed, meaning that overall the monitoring systems were not effective.

Staffing arrangements were not always adequate to meet the needs of residents. The daily roster, was insufficient to ensure that residents could access the community, and while there was an absence on the day of inspection, arrangements were not in place to meet the needs of residents.

Staff training was not up to date, including the requirement for staff to have current training in relation to the protection of vulnerable adults. Updates needed for staff training had been identified in audits but had not been put in place.

The person in charge had been asked to provide an up to dated evidence of garda vetting but at the time of inspection this requirement had not been complied with despite a number or requests for same.

Overall there were inadequate systems and processes in place to ensure the safety and quality of care and support to residents in this designated centre. This lack of oversight was leading to negative outcomes for residents, as reflected in the high level of non-compliance with the regulations and as set out further in the quality and safety section of this report.

Regulation 14: Persons in charge

The overall arrangements for the post of person in charge required review. The current post holder had a range of other responsibilities and was not based in the centre and the provider had identified the need for a revised arrangement. Duties

which were the responsibility of the person in charge were not appropriately delegated.

The person in charge who was in post at the time of inspection was appropriately experienced and qualified, but had not submitted the documentation required in Schedule 2 of the regulations.

Judgment: Not compliant

Regulation 15: Staffing

Staffing arrangements required review to ensure that residents' needs were consistently met.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Not all staff training was up to date.

Judgment: Substantially compliant

Regulation 23: Governance and management

The provider had not ensured that there was a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision; or that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored;

Judgment: Not compliant

Quality and safety

While there was evidence of some very person-centred and caring interactions between staff and residents, overall the quality of care and support in this centre was not adequate to meet the needs of residents on a consistent basis. The environment was not homelike, and residents were not fully supported to have a comfortable and meaningful life of their choosing.

This designated centre was not appropriately designed and laid out to meet the needs of residents. It did not provide a homelike environment. On entrance there was an office and large communal sitting area with seating arranged around the perimeter of this area. Corridors ran off from this entrance, and residents' bedrooms were located on these corridors, as were storage rooms and offices, some of which were occupied by personnel not involved in the centre. As a result of the way the centre was organised the kitchen was an industrial-type facility that residents had no access to. While staff tried their best to involve residents in cooking activities on special occasions, residents did not enjoy a kitchen area as part of their daily life. There was also no access to the laundry facilities for residents. This meant that residents could not engage in the normal activities of daily living and residents did not live in a home-like environment.

Many parts of the premises were not in a good state of repair. The paintwork throughout the centre was chipped, faded and in need of repair. There was damp issue which was affecting a large section of the premises, including a number of bedrooms, that required urgent attention. In particular the damp in one of the resident's bedrooms had not only discoloured and damaged the walls, but had resulted in odour problems and also presented an infection control issue. The person in charge described planned works to address this issue and an identified time frame of 31 December 2019 had been set in the quality improvement plan for the completion fo this remedial work. However, it was apparent that this time frame would not be met.

Residents were not getting out of the centre enough. Inspectors saw feedback from residents to the provider which stated this. Whilst it was clear that efforts had been made by staff to effect a community presence and involvement for residents, this had so far only resulted in a once a week outing for some residents, and for others fewer than this. For some residents most of their time was spent in the designated centre. Staff reported that they made an effort to ensure that each resident went out 'once a week'. Inspectors observed a resident with limited sight spending the majority of their morning rocking and vocalising and having no meaningful activity. A review of activity records revealed that another resident who was described as enjoying weekly outings had only one recorded outing in 2019.

There was insufficient evidence of the upholding of residents' rights. Personnel not involved in the centre had offices in the centre which did not support a home-like environment. There was very obvious signage in residents' rooms and throughout the centre that related to staff instruction, and were not for residents, many of whom could not read these signs.

While the provider had made improvements to decorate and personalise a number of residents' rooms further improvements were needed to ensure the centre

reflected residents' preferences. For example, it was not evident that residents had been consulted about the timing of meals and snacks. Inspectors noted that the main meal service commenced at 12.15 pm. It was not evident that this was reflective of preference.

The standard of personal plans was inadequate, There was a personal plan in place for most residents, but not for a resident who had been admitted three months prior to the inspection. Where care plans were in place, some parts of these plans were of a high standard, indicating that staff had the skills required to formulate such plans. However, some of the information in these plans was vague in relation to healthcare needs, so that there was a risk of important guidance being overlooked. Information in relation to social care was not adequate to ensure the needs of residents were met.

The personal plans did not include plans to maximise the potential of each person as required by the regulations. Goals for residents included such guidance as 'I don't want to go to bed at 7.30' as previously mentioned. There was no evidence of residents being involved in the development of these plans. Person centred plans were not in the possession of residents, they were all located on a shelf in the activities room, and not kept securely.

Where residents required positive behaviour support there were detailed assessments and plans in place. These had been recently reviewed and updated by a skilled member of staff and included an in depth analysis of data from the recordings of any incidents.

There was a process in place to review any restrictive practices, however the inspectors did not find sufficient evidence that all alternatives had been considered and ruled out for one of the restrictions in place. This restrictive practice was unusual and required compliance with the regulations, which was not evident.

There were structures and processes in place to mitigate the risk of fire and the provider had demonstrated that residents could be safely evacuated in the event of an emergency. However some of the guidance for staff in personal evacuation plans was ambiguous and therefore these plans were in need of review and update.

The provider had put systems in place to identify, record and mitigate risks in the centre. Accidents and incidents were recorded and there was evidence of review to prevent further re occurrence. For the most part risk management systems were being followed, however, it was noted that risks associated with the premises maintenance and damp had not been adequately assessed.

Regulation 13: General welfare and development

The provider did not ensure adequate opportunities for residents to participate in activities in accordance with their interests, capacities and developmental needs. The centre was not managed and organised to reflect residents' choices and

preferences. Residents were not getting out of the centre as frequently as they wished.

Judgment: Not compliant

Regulation 17: Premises

While efforts had been made to improve some parts of the physical environment, the premises remained unsuitable to meet the needs of residents in that there was an institutional-style layout with no access to the usual facilities of a home such as kitchen and laundry. The premises were not maintained to an acceptable standard, in particular in relation to damp.

Judgment: Not compliant

Regulation 26: Risk management procedures

There were systems in place in relation to risk management, however not all risks had been identified and mitigated.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Precautions had been taken against the risk of fire, although guidance in some of the personal evacuation plans was ambiguous and required review.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Personal plans were in place for residents, however they did not show evidence of adequate assessment, consultation and maximising the potential of residents.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Positive behaviour support was available to residents and was informed by good quality assessment.

However, the process for managing and reviewing restrictive practices required review. Not all alternatives to restrictive practices had been considered.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Not compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 13: General welfare and development	Not compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Not compliant

Compliance Plan for Inbhear Na Mara OSV-0002496

Inspection ID: MON-0024222

Date of inspection: 03/12/2019

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 14: Persons in charge	Not Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: A Garda Vetting application has been submitted to the Garda Vetting Bureau for the current person in charge. This will be forwarded to the Health Information and Quality Authority once received. • A Clinical Nurse Manager 2 has been identified and will be appointed to the centre by the 14/02/2020 to ensure appropriate governance and management of the Centre. • This Clinical Nurse Manager 2 will be based in the designated centre and will be responsible for this designated centre only.	
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: A review of the centre's roster will be completed to ensure the needs of all residents are met – completed 10/01/2020. • Arising from the above, there is a minimum of 2 nurses on duty at all times. • This review and change will now ensure that residents will be facilitated to access the community as per their personal preferences.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: 12 staff will undertake refresher training in Safeguarding. This is scheduled for 28/02/2020. • 18 staff will undertake training in behavior management. This is scheduled for 20/03/2020. • 3 staff will undertake refresher training in Fire Precautions. This is scheduled for 28/02/2020.	

• Monthly review of the training matrix will be undertaken to ensure that staff training is maintained and delivered in line with the mandatory requirements

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
In order to bring the service into compliance with this regulation the following will be undertaken:
• A Clinical Nurse Manager 2 has been identified and will be appointed to the centre by the 14/02/2020 to ensure appropriate governance and management of the Centre.
• This Clinical Nurse Manager 2 will be based in the designated centre and will be responsible for this designated centre only.
• A number of outstanding actions arising from the previous 6 monthly unannounced visit have been reviewed and a timeframe identified for completion. Identified building and painting works have been scheduled for completion by 24/04/2020.

To ensure appropriate implementation of the current monitoring and oversight system (which includes scheduled audits and provider nominee unannounced visits) on an on-going basis, the following will be undertaken:
• All audits will be completed by the Person in Charge with immediate effect
• Any actions arising will be monitored through the centres quality improvement plan
• On appointment of the Person in Charge, the Regional Director of Nursing will provide onsite mentoring support in relation to increasing the effectiveness of the monitoring system – to be completed by 28/02/2020

Regulation 13: General welfare and development	Not Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
A review of each resident's daily activities will be completed and schedules developed to ensure all residents are fully supported to participate in meaningful activities within and outside the centre – to be completed by 31/01/2020.
• A planned schedule of weekly social activities, to include access to ordinary places, will be developed and implemented to ensure all residents have maximum opportunity to engage in their community. The schedule will identify what activities have been offered and what activities residents chose to undertake.
• Resident's enjoyment levels of these activities will be recorded to ensure effective evaluation of their participation with social activities identified.

Resident's preferences in relation to the running of the centre will be a specific agenda item at resident's meetings going forward. This will include access to laundry facilities, meal preparation and meal times.

For example, access to laundry facilities will be the specific focus on the agenda for 14/01/2020. Arising from same all residents who wish to access laundry facilities will be supported and facilitated by support staff to do so.

While residents do not have access to the industrialised kitchen, which is a main production HACCP kitchen, there is a separate kitchen which is available for residents at all times. The kitchen is equipped as follows – Fridge; Toaster; Kettle; Storage area; Cupboards; Sink; Microwave; Dishwasher; Wash Hand basin. This kitchen will be upgraded to include a hob, oven, extractor fan and a range of cooking and baking utensils. Residents will be supported by Staff to access this kitchen for baking and the preparation of snacks and meals in line with residents' preferences and wishes.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
In order to bring the service into compliance with this regulation the following will be undertaken:
• Damp proofing resin will be inserted in the damp affected walls throughout the centre – scheduled for completion by 20/03/2020. Update: This work is underway and will be completed by 28/02/2020.
• On completion of damp proofing all affected areas will be painted and decorated in line with resident's wishes – scheduled for completed by 24/04/2020
• Office space will no longer be provided for external staff as of 28/02/2020 Update: This action has been completed.
• All obvious signage and labels from bedroom and living area furniture will be removed - completed as 10/01/2020-
• Residents will be supported to personalise the living areas throughout the centre including bedrooms, bathrooms and communal areas Update: Work on this action has commenced.
Resident's preferences in relation to the running of the centre will be a specific agenda item at resident's meetings going forward. This will include access to laundry facilities, meal preparation and meal times.
For example, access to laundry facilities will be the specific focus on the agenda for 14/01/2020. Arising from same all residents who wish to access laundry facilities will be supported and facilitated by support staff to do so. Update: This action was completed on 14.01.2020 and will continue to be discussed at residents meetings on an ongoing basis.

There is a separate kitchen which is available for residents at all times. The kitchen is equipped as follows – Fridge; Toaster; Kettle; Storage area; Cupboards; Sink; Microwave; Dishwasher; Wash Hand basin.

Update:

The centre's separate kitchen will be upgraded to include a hob, oven, extractor fan and a range of cooking and baking utensils. This will be completed by 24/04/2020. Residents will be supported by staff to access this kitchen for baking and preparation of snacks and meals in line with residents' preferences and wishes.

An assessment of this centre has been completed by the HSE Estates Department on the 18/02/2020 in order to provide advice to reduce the institutional nature of the building. This advice will inform the furnishing and decoration of the centre, with particular

attention to the entrance area which includes a kitchenette and sitting room.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
In order to bring the service into compliance with this regulation the following will be undertaken:
• Review of all the centre's risks have been undertaken and completed as of 13/12/2019.
• Risks that could not be addressed at centre level were escalated to the Provider Nominee – 13/12/2019
• A plan is now in place to mitigate against these risks.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Each resident's personal emergency evacuation plans will be updated and fully completed by 14/01/2020
• All staff have been briefed on progressive internal evacuation – this will be included in each residents' personal emergency evacuation plan and will be completed by 14/01/2020

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
A review of each resident's person centred plan was completed by 31/12/2019 in consultation with the resident.
• An accessible Person Centred Plan will be developed for each resident which will be securely stored in the nurse's office. Residents will be provided with access to same in line with their preferences – to be completed by 31/01/2020

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
A multidisciplinary review meeting was convened on 07/01/2020 and a full review of the use of one restrictive practice within the centre was completed.
• All alternatives were considered by the Multidisciplinary Team and a decision taken to continue to use the current practice – 07/01/2020
• A referral has been made for psychology input – 07/01/2020
• The protocol for same has been reviewed, updated and approved by the Multi-disciplinary Team – 07/01/2020
• This practice will be reviewed on a 6 monthly basis.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Not Compliant	Orange	31/01/2020
Regulation 14(5)	The registered provider shall ensure that he or she has obtained, in respect of the person in charge, the information and documents specified in Schedule 2.	Not Compliant	Orange	31/01/2020
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of	Substantially Compliant	Yellow	10/01/2020

	the residents, the statement of purpose and the size and layout of the designated centre.			
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	20/03/2020
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	Orange	24/04/2020
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Not Compliant	Orange	24/04/2020
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the	Not Compliant	Orange	14/02/2020

	lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.			
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	28/02/2020
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	13/12/2019
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Substantially Compliant	Yellow	14/01/2020
Regulation 05(4)(b)	The person in charge shall, no later than 28 days	Substantially Compliant	Yellow	31/01/2020

	after the resident is admitted to the designated centre, prepare a personal plan for the resident which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.			
Regulation 07(5)(b)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation all alternative measures are considered before a restrictive procedure is used.	Not Compliant	Orange	07/01/2020